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MO HealthNet Managed Care

Quality Assessment & Improvement Advisory Group

Tuesday, March 22, 2022

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WELCOME

PRESENTED BY: MARK KAPP

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Today's Agenda

- Behavior Health Update
- Biopsychosocial Treatment for Obesity
- MHD Update
- CCBHOs
- Pharmacy Update
- Break
- Data Update
- Legal Aid
- Questions & Comments

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Behavioral Health Update

Presented by:
Eric Martin Ph. D.
Amber McCadney-McKenzie

QA&I Meeting:

Behavioral Health Updates

March 22, 2022

Missouri Department of SOCIAL SERVICES

Behavioral Health Updates: 7/1/2022 Contract

Specialty Plan for COA 4: Mission Statement

To establish a trauma-informed, comprehensive and integrated BH/PH delivery system that allows children and youth - in the care of the state, receiving adoption or guardianship subsidy assistance, or persons under age 26 formerly in foster care - to grow into healthy adults and live full and satisfying lives.

Specialty Plan: Trauma Informed Approach to Care Management

- All Care Management Activities Must Incorporate Five Key Principles of the Missouri Model

- Safety
- Trustworthiness
- Choice
- Collaboration
- Empowerment

The Missouri Model: A Developmental Framework for Trauma Informed (https://www.cfechildwellbeing.org/becoming-trauma-informed).

Specialty Plan: Comprehensive Community Support Services

The Specialty Plan is required to provide comprehensive community support (CCS) rehabilitation services. CCS services are covered for members who have behavioral conditions that require rehabilitative services in a Children's Division (CD)-licensed residential facility, qualified residential treatment program (QRTP)*, treatment foster home. CCS also includes residential aftercare and transition treatment foster care.

*QRTP -- A designated, non family-based placement designed to help serve children with higher treatment needs that warrant a short-term placement outside of their family home.

Specialty Plan: In Lieu of Services

In lieu of services (ILOS) options can be considered if medically appropriate and cost effective substitute for covered services.

Partial Hospital Program (PHP)

PHP services consistent with the requirements in 42 CFR 410.43 in lieu of psychiatric/substance use inpatient services, PRTF services, or other higher levels of psychiatric/substance use services.

Intensive Outpatient Program (IOP)

IOP in lieu of psychiatric/substance use inpatient services, PRTF services, or other higher levels of psychiatric/substance use services.

Inpatient Diversion/Stepdown

In lieu of psychiatric or substance use inpatient care to adults age twenty-one (21) and older for up to ninety (90) days annually, and for children under the age of twenty-one (21) with no annual limit.

General & Specialty Plans: Mental Health Parity

Mental Health Parity Update – Contract Section: 2.6.8

- The health plan shall be prohibited from requiring prior authorization for in-network behavioral health services unless approved in advance by the state agency in writing.
- The health plan's request for approval must include the following:
  - List of behavioral health services proposed to be subject to prior authorization,
  - A summary of the health plan's analysis that demonstrates the prior authorization requirements comply with the mental health parity requirements in 42 CFR 438.910(d).

General & Specialty Plans: Certification Review Update

- Currently, contract requires Level of Care Utilization System (LOCUS) for adults and Child and Adolescent Level of Care Utilization System (CALOCUS) for youth.
- CALOCUS-CASII – newly merged instrument:
  - https://calocus-casii.org/
  - https://www.aacap.org/AACAP/Member_Resources/Practice_Information/CALOCUS_CASII.aspx

- Effective July 1, 2022, general and specialty plan contracts will require:
  - LOCUS – members over 18
  - Child and Adolescent Level of Care/Service Intensity Utilization System (CALOCUS-CASII) – members 6 to 18
  - Early Childhood Service Intensity Instrument (ECSII) – members under 6

General & Specialty Plans: Psychiatric Residential Treatment Facilities

Required coverage for state and privately operated PRTFs that deliver psychiatric residential treatment services to youth with serious emotional disturbance when the youth cannot be treated in an alternative level of care.

General & Specialty Plans

Psychiatric Residential Treatment Facilities (PRTFs)

- Non-hospital facility with a provider agreement to provide inpatient psych under 21 benefit
- Provides comprehensive mental health treatment
- Offers short-term, intense, and focused mental health treatment
- Active engagement with youth's family, other agencies, and community

Private PRTF facilities were added via Medicaid State Plan Amendment effective October 1, 2021.

Beginning July 1, 2022, MHD managed care plans will cover PRTF services for their members.

PRTF Updates Effective July 1, 2022

- Health plans are required to reimburse at least the state agency Fee-for-Service fee schedule rate
- The state operated PRTF shall receive the trended cost per day as calculated by DMH for that state fiscal year (same as FFS).
- Children and youth will no longer need to change health plan providers to FFS in order to be admitted by Hawthorn for services.
- PRTF admissions, continued stay reviews, and retrospective reviews also require:
  - LOCUS for members over age 18,
  - CALOCUS-CASII for members aged 6-18, and
  - The ESCII for members under age 6.

Contact Info:

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Biopsychosocial Treatment for Obesity

Presented by:

Sarah Hampl

Denise Wilfley

MO MEDICAID OBESITY TREATMENT BENEFIT OVERVIEW

Sarah Hampl, MD
Children's Mercy
Kansas City

Denise Wilfley, PhD
Washington University-St. Louis

"Obesity is associated with a range of diseases, including type 2 diabetes, heart disease, stroke, arthritis, sleep apnea, and many types of cancers. Obesity is estimated to increase ***healthcare spending by $149 billion annually (about half of which is paid for by Medicare and Medicaid).***"

The State of Obesity: Better Policies for A Healthier America, 2021.

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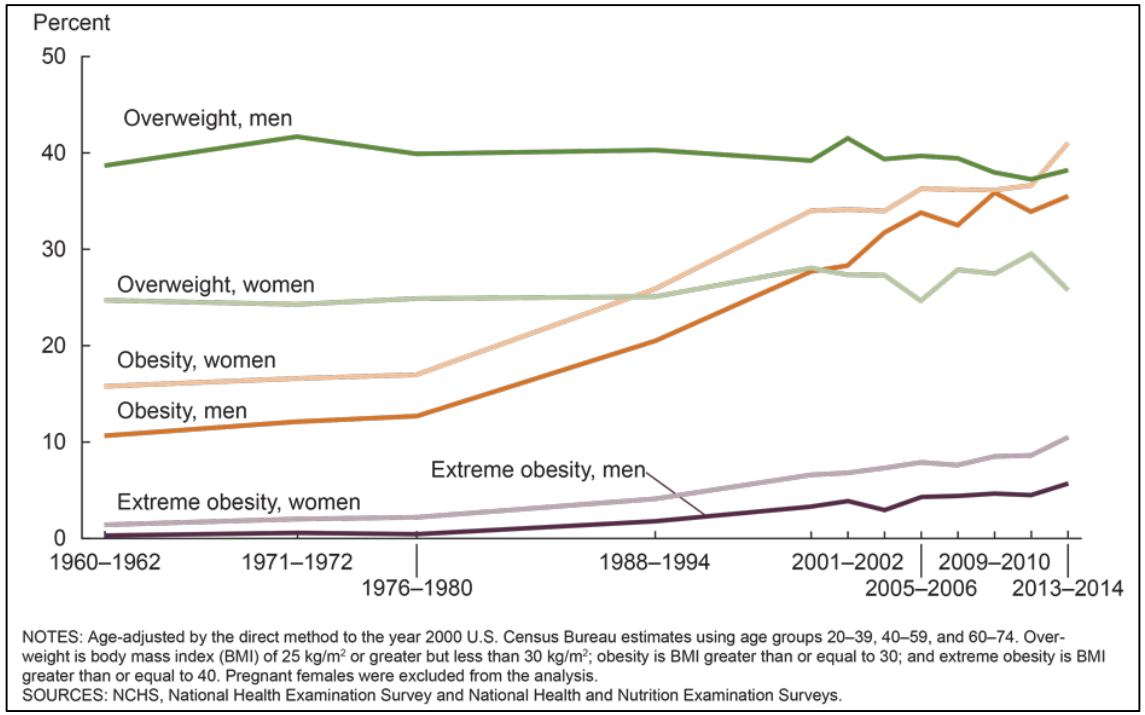
FOUNDATIONAL PRINCIPLES OF MO HN BIOPSYCHOSOCIAL OBESITY TREATMENT BENEFIT

- Obesity is a complex chronic disease with medical, psychological and social etiologies and consequences; its treatment must include intervention in these 3 areas
- "The intent is to provide integrated medical nutrition and behavioral health services, coordinated by the primary care provider, to facilitate behavior changes to manage obesity and associated co-morbidities."
- Benefit is based on US Preventive Services Task Force Recommendations for adults and children with obesity

ADULT OBESITY TRENDS

Trends in adult overweight, obesity and extreme obesity among men and women aged 20-74: United States, 1960-1962 through 2013-2014



NOTES: Age-adjusted by the direct method to the year 2000 U.S. Census Bureau estimates using age groups 20–39, 40–59, and 60–74. Overweight is body mass index (BMI) of 25 kg/m^2 or greater but less than 30 kg/m^2; obesity is BMI greater than or equal to 30; and extreme obesity is BMI greater than or equal to 40. Pregnant females were excluded from the analysis.
SOURCES: NCHS, National Health Examination Survey and National Health and Nutrition Examination Surveys.

https://stateofobesity.org/files/stateofobesity2017.pdf

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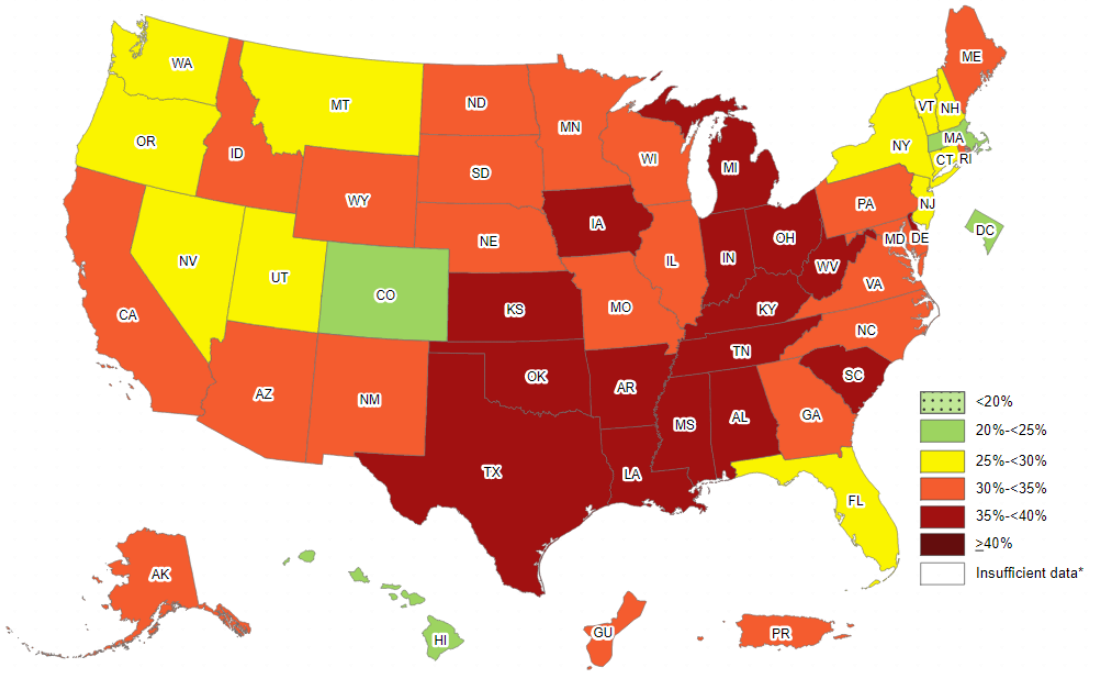
*Prevalence of Self-Reported Obesity Among U.S. Adults by State and Territory, BRFSS, 2020

* Prevalence estimates reflect BRFSS methodological changes started in 2011. These estimates should not be compared to prevalence estimates before 2011.



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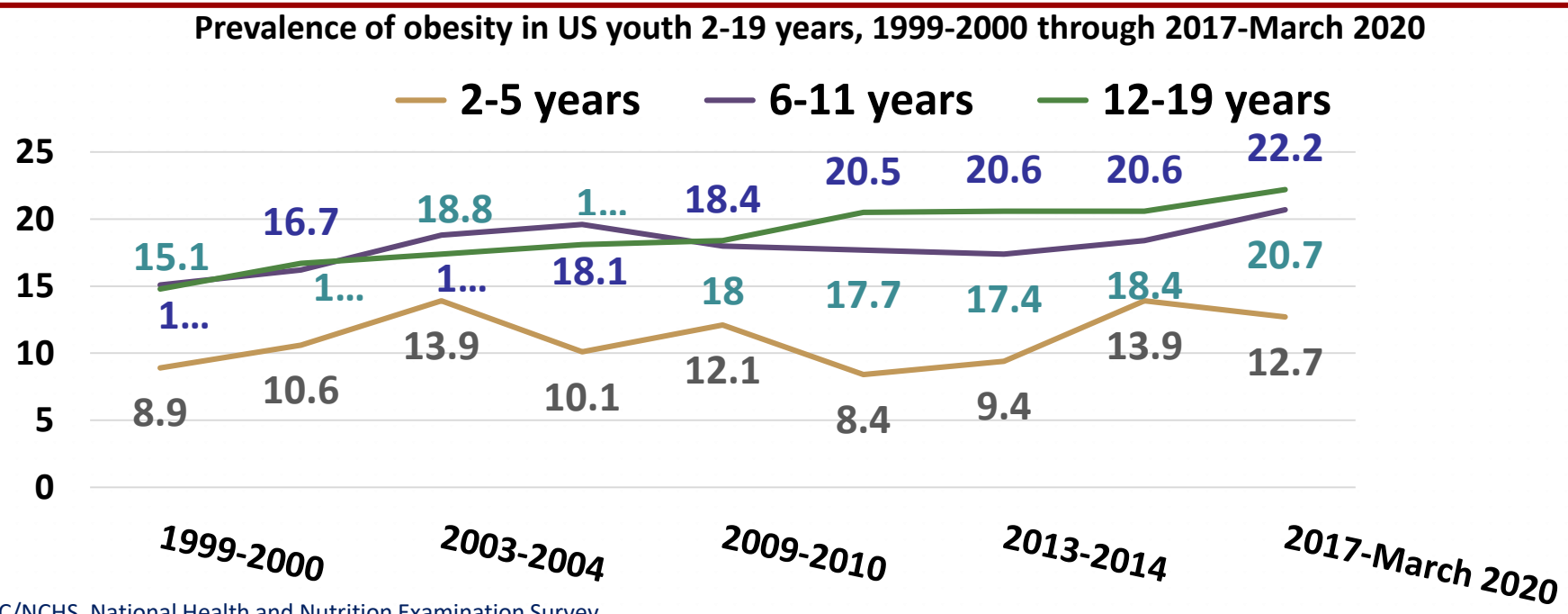
CHILDHOOD OBESITY TRENDS
NATIONAL HEALTH AND NUTRITION EXAMINATION SURVEY



CDC/NCHS, National Health and Nutrition Examination Survey

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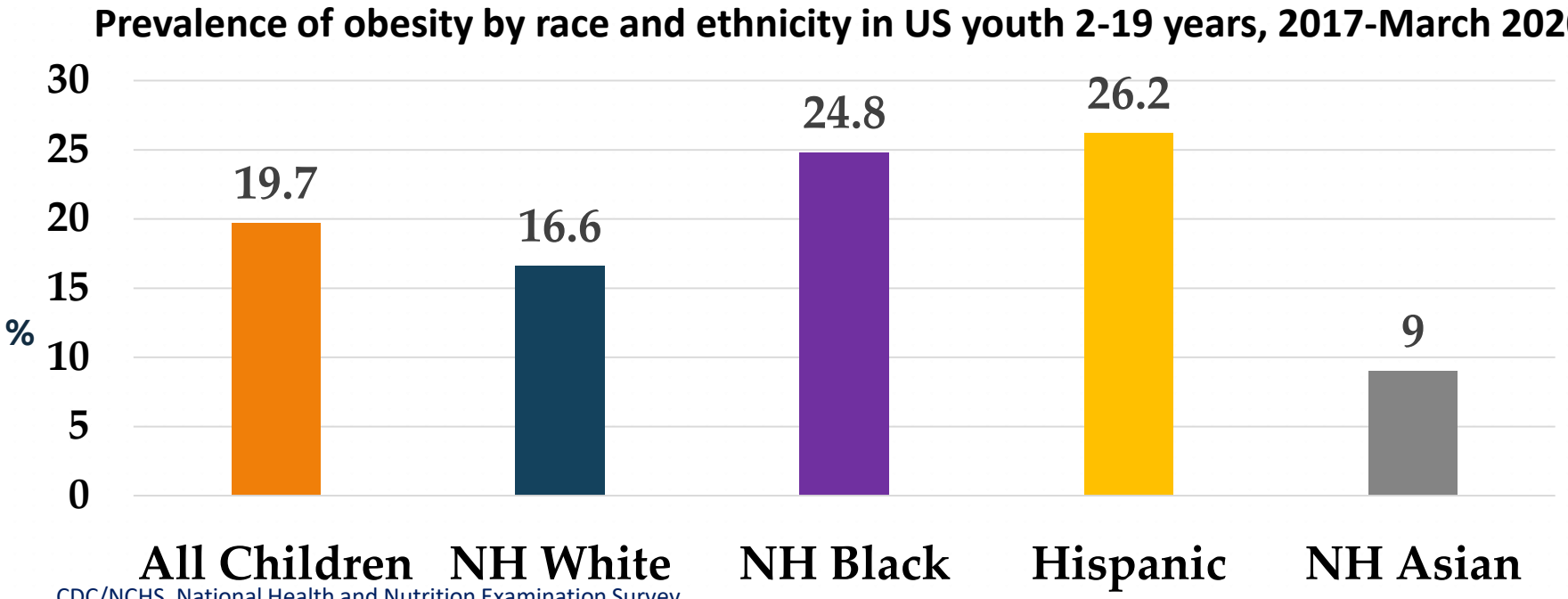

CDC/NCHS, National Health and Nutrition Examination Survey

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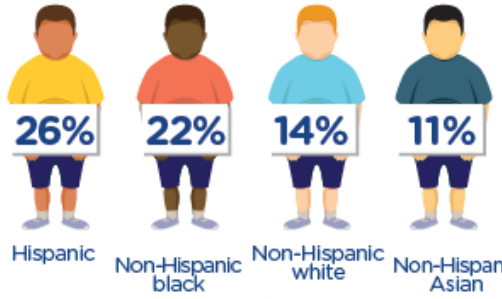
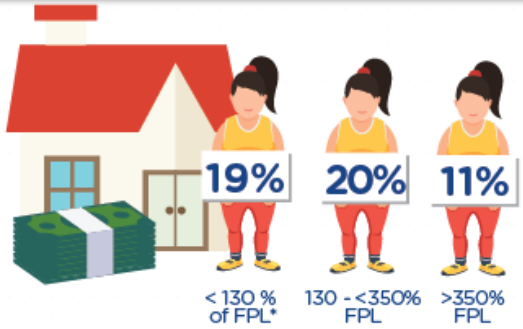
Disparities in Child Obesity Prevalence

By Race and Ethnicity



By Household Income



By Metropolitan Status

21.7%
9.4% severe obesity

17.1%
5.1% severe obesity

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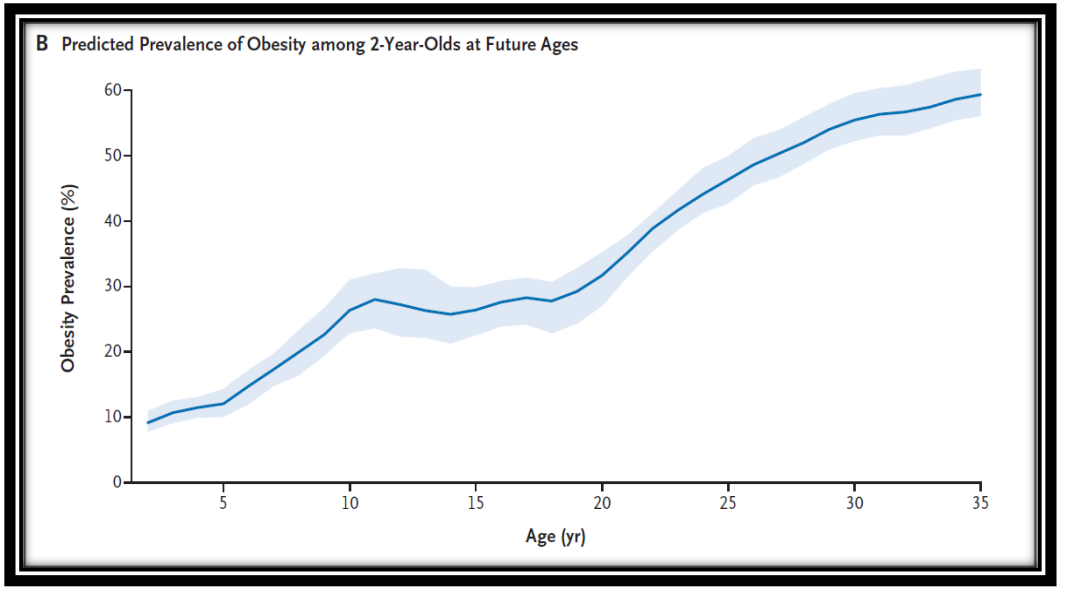
Future Predictions for Childhood Obesity

By 2050, the majority of today's children (57.3%) will have obesity by age 35, if our society doesn't take immediate actions



Source: Ward ZJ, Long MW, Resch SC, et al. N Engl J Med. 2017 Nov 30;377(22):2145-2

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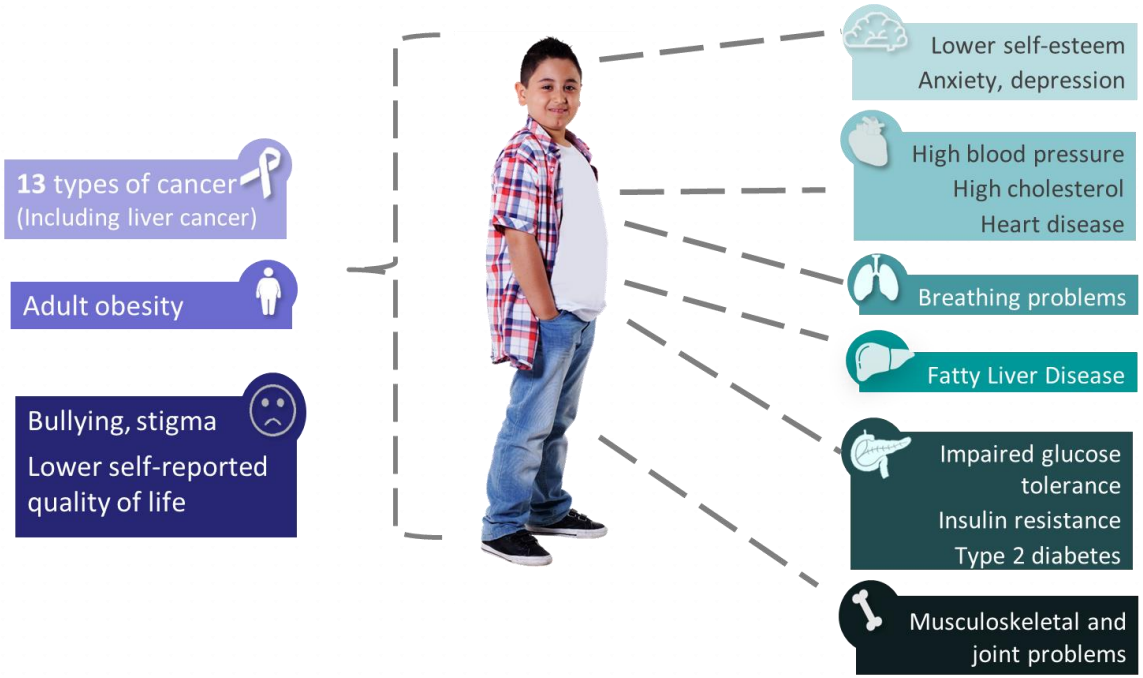
Immediate & Future Health Risks



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Theoretical Impacts of the Pandemic on Children's Health

Disrupted Routines

- Remote learning
- Stress in the home
- Irregular mealtimes
- Fewer PA opportunities
- Food insecurity

Unhealthy Behaviors

- Consumption of SSBs & processed foods
- Less PA
- Increased screen time
- Disrupted sleep

Weight Changes

Mental Health Concerns

"It's a case of one health crisis exacerbating another health crisis"

"From a health standpoint, 2020 looked like a 10-month summer."

Relevant Sources:
Weight gain during COVID-19. October 13, 2020. https://www.chop.edu/news/health-tip/weight-gain-during-covid-19
The pandemic and childhood weight gain. January 4, 2021. https://now.tufts.edu/articles/pandemic-and-childhood-weight-gain
Remote learning during COVID-19 is causing children to gain weight, doctors warn. February 14, 2021. https://www.wsj.com/articles/remote-learning-during-covid-19-is-causing-children-to-gain-weight-doctors-warn-11613298602 https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(21)00168-7/fulltext

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Accelerated Weight Gain During the Pandemic

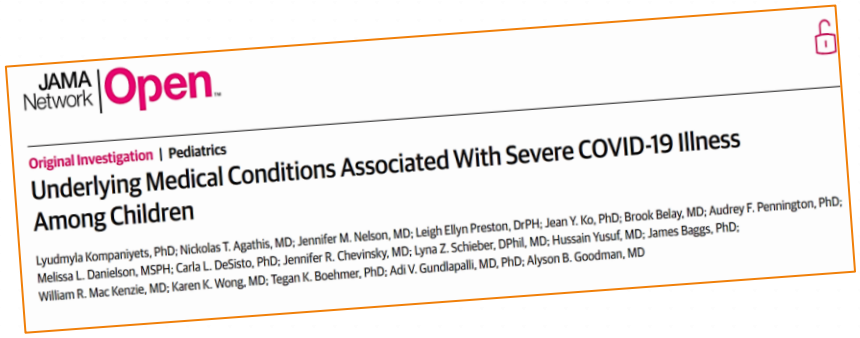
- Data Source: IQVIA Ambulatory EMR; 100K providers from >800 sites
- Longitudinal Cohort: 432,302 children 2-19y with ≥3 BMI measurements

- During pandemic:
  - Healthy weight: 0.5 lb/month
    - 2.7 lb/6 months
  - Obesity: 1-1.2 lb/month
    - 6.1-7.3 lb/6 months

Monthly Rate of Change in Children's Weight in Pounds Before and During the COVID-19 Pandemic & Expected Weight Gain Over Time

	Pre-Pandemic			During Pandemic		
		Estimated Wt. Gain			Estimated Wt. Gain	
	Slope	6 mos.	12 mos.	Slope	6 mos.	12 mos.
Overall	0.36	2.1	4.3	0.60	3.6	7.1
BMI Category						
Underweight	0.21	1.3	2.5	0.29	1.7	3.5
Healthy Weight	0.28	1.7	3.4	0.45	2.7	5.4
Overweight	0.41	2.5	4.9	0.73	4.4	8.7
Moderate Obesity	0.54	3.3	6.5	1.01	6.1	12.1
Severe Obesity	0.74	4.4	8.8	1.22	7.3	14.6

Obesity as a Risk Factor for COVID-19 Illness

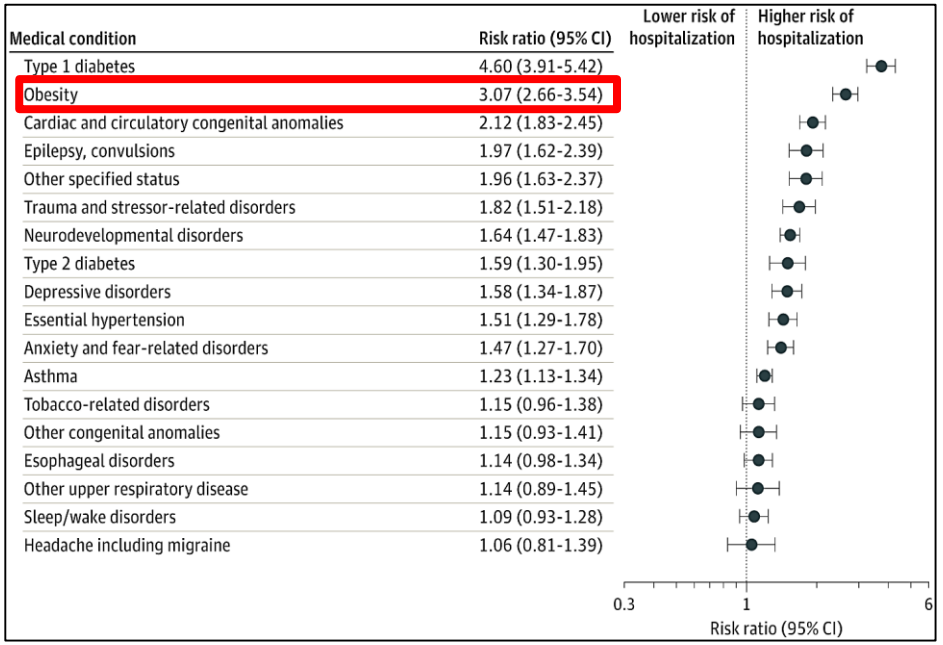


JAMA Network Open

Original Investigation | Pediatrics

Underlying Medical Conditions Associated With Severe COVID-19 Illness Among Children

Lyudmyla Kompaniyets, PhD; Nickolas T. Agathis, MD; Jennifer M. Nelson, MD; Leigh Ellyn Preston, DrPH; Jean Y. Ko, PhD; Brook Belay, MD; Audrey F. Pennington, PhD; Melissa L. Danielson, MSPH; Carla L. DeSisto, PhD; Jennifer R. Chevinsky, MD; Lyna Z. Schieber, DPhil, MD; Hussain Yusuf, MD; James Baggs, PhD; William R. Mac Kenzie, MD; Karen K. Wong, MD; Tegan K. Boehmer, PhD; Adi V. Gundlapalli, MD, PhD; Alyson B. Goodman, MD



Medical condition	Risk ratio (95% CI)
Type 1 diabetes	4.60 (3.91-5.42)
Obesity	3.07 (2.66-3.54)
Cardiac and circulatory congenital anomalies	2.12 (1.83-2.45)
Epilepsy, convulsions	1.97 (1.62-2.39)
Other specified status	1.96 (1.63-2.37)
Trauma and stressor-related disorders	1.82 (1.51-2.18)
Neurodevelopmental disorders	1.64 (1.47-1.83)
Type 2 diabetes	1.59 (1.30-1.95)
Depressive disorders	1.58 (1.34-1.87)
Essential hypertension	1.51 (1.29-1.78)
Anxiety and fear-related disorders	1.47 (1.27-1.70)
Asthma	1.23 (1.13-1.34)
Tobacco-related disorders	1.15 (0.96-1.38)
Other congenital anomalies	1.15 (0.93-1.41)
Esophageal disorders	1.14 (0.98-1.34)
Other upper respiratory disease	1.14 (0.89-1.45)
Sleep/wake disorders	1.09 (0.93-1.28)
Headache including migraine	1.06 (0.81-1.39)

Kompaniyets L, Agathis NT, Nelson JM, et al. Underlying medical conditions associated with severe COVID-19 illness among children. JAMA Netw Open. 2021;4(6):e2111182. doi: 10.1001/jamanetworkopen.2021.11182

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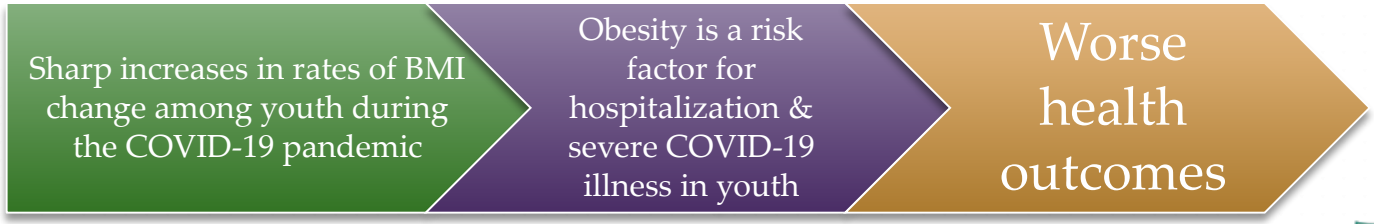
Childhood Obesity & The COVID-19 Pandemic

- **Children and adolescents** (2-19y) **experienced sharp increases in their rates of BMI change during the early COVID-19 pandemic**
  - Average rate of BMI increase nearly doubled during the early pandemic (Mar-Nov 2020)
  - Groups most affected: children with overweight or obesity & children aged 6-11y
- **Among children and adolescents** (≤18y) **with COVID-19, underlying medical conditions, including obesity, increased the likelihood for hospitalization and severe COVID-19 illness** (ICU admission, IMV, or death)



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Recommended Pediatric Weight Management Intervention (PWMI)

Evidence Base:

Over **60** Randomized Controlled Trials show us that family-centered pediatric weight management interventions (PWMI) can result in 5-20% reduction in excess weight

U.S. Preventive Services Task Force Recommendation (2017):

Grade B*

Physicians should **screen children ages 6+** using BMI and offer/refer children with obesity to intensive, **family-centered PWMI**

PWMIs should have **26+ hours** of counseling over 2-12 months on **nutrition**, **physical activity**, and **behavior change**.

* Under the ACA Grade B recommendation means that insurers must cover screening and treatment in intensive interventions as a preventive service.

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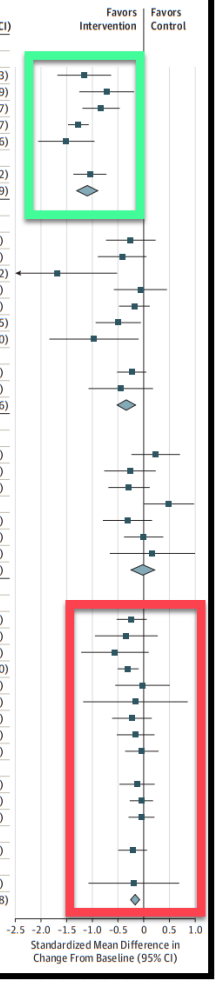
Source	Estimated Contact Hours Through 12 mo	Months Since Randomization (Months Since End of Treatment)	Intervention No.	Intervention Change From Baseline, Mean (SD)	Control No.	Control Change From Baseline, Mean (SD)	Standardized Mean Difference in Change From Baseline (95% CI)
Estimated contact ≥52 h							
Outcome: BMI *z* score							
Weigel et al,[64] 2008	114	12 (0)	36	-0.34 (0.48)	30	0.26 (0.57)	-1.15 (-1.68 to -0.63)
Savoye et al,[51] 2014	78	6 (0)	31	-0.05 (0.13)	27	0.04 (0.12)	-0.72 (-1.25 to -0.19)
Reinehr et al,[45] 2006	78	12 (0)	174	-0.30 (0.35)	37	0 (0.41)	-0.83 (-1.19 to -0.47)
Reinehr et al,[46] 2009	78	12 (0)	288	-0.22 (0.35)	186	0.15 (0.17)	-1.27 (-1.47 to -1.07)
Reinehr et al,[47] 2010	67	6 (0)	34	-0.26 (0.22)	32	0.05 (0.19)	-1.50 (-2.05 to -0.96)
Outcome: BMI							
Savoye et al,[52] 2007	82	12 (0)	105	-1.7 (3.1)	69	1.6 (3.2)	-1.05 (-1.37 to -0.72)
Subtotal (I^2 = 43.4%; P = .12)							-1.10 (-1.30 to -0.89)
Estimated contact 26-51 h							
Outcome: BMI *z* score							
Vos et al,[61] 2011[a]	45	12 (NA[b])	32	-0.40 (1.3)	35	-0.1 (1.1)	-0.25 (-0.73 to 0.23)
Kalavainen et al,[34] 2007	44	12 (6)	35	-0.30 (0.15)	35	-0.20 (0.30)	-0.42 (-0.89 to 0.05)
Stark et al,[54] 2011	38	12 (6)	7	-0.37 (0.41)	9	0.40 (0.49)	-1.68 (-2.85 to -0.52)
Croker et al,[26] 2012	38	6 (0)	31	-0.11 (0.16)	27	-0.10 (0.16)	-0.06 (-0.58 to 0.45)
DeBar et al,[29] 2012[a]	37	12 (7)	90	-0.15 (0.41)	83	-0.08 (0.36)	-0.18 (-0.48 to 0.12)
Sacher et al,[49] 2010	36	6 (3.75)	37	-0.30 (0.51)	45	-0.01 (0.65)	-0.49 (-0.94 to -0.05)
Stark et al,[53] 2014	30	12 (16)	11	-0.59 (0.75)	12	-0.03 (0.36)	-0.97 (-1.84 to -0.10)
Outcome: BMI							
Kalarchian et al,[33] 2009	44	12 (0)	97	0.50 (3.0)	95	1.1 (2.2)	-0.23 (-0.52 to 0.05)
Nemet et al,[42] 2005[a]	33	12 (9)	20	-1.6 (4.3)	20	0.60 (5.5)	-0.45 (-1.07 to 0.18)
Subtotal (I^2 = 24.0%; P = .23)							-0.34 (-0.52 to -0.16)
Estimated contact 6-25 h							
Outcome: BMI *z* score							
Bryant et al,[25] 2011	24	12 (0)	35	0.03 (0.24)	35	-0.03 (0.27)	0.23 (-0.24 to 0.70)
Golley et al,[31] 2007	24	12 (7)	31	-0.24 (0.43)	31	-0.13 (0.40)	-0.26 (-0.76 to 0.24)
Hofsteenge et al,[32] 2014	17	6 (0)	53	-0.12 (0.46)	44	0.02 (0.53)	-0.28 (-0.68 to 0.12)
Gerards et al,[30] 2015	17	12 (8.5)	35	0.05 (0.26)	32	-0.08 (0.27)	0.49 (0.00 to 0.98)
Nowicka et al,[41] 2008	16	12 (0)	65	-0.06 (0.46)	23	0.09 (0.53)	-0.31 (-0.79 to 0.16)
Norman et al,[65] 2016	12	12 (0)	53	-0.10 (0.36)	53	-0.10 (0.44)	0.00 (-0.38 to 0.38)
Arauz Boudreau et al,[23] 2013	11	6 (0)	13	-0.03 (0.14)	10	-0.05 (0.08)	0.17 (-0.66 to 1.00)
Subtotal (I^2 = 37.4%; P = .14)							-0.02 (-0.25 to 0.21)
Estimated contact 0-5 h							
Outcome: BMI *z* score							
Taylor et al,[59] 2015	5	12 (NA[b])	91	-0.19 (0.52)	90	-0.08 (0.43)	-0.23 (-0.53 to 0.06)
Stettler et al,[55] 2015[a]	4	12 (0)	46	-0.06 (0.50)	24	0.10 (0.41)	-0.34 (-0.95 to 0.27)
Saelens et al,[50] 2002[a]	4	7 (3)	18	-0.05 (0.22)	19	0.06 (0.17)	-0.56 (-1.22 to 0.10)
Broccoli et al,[28] 2016	4	12 (9)	186	-0.12 (0.38)	185	-0.01 (0.35)	-0.30 (-0.51 to -0.10)
Sherwood et al,[66] 2015	3	6 (0)	26	-0.02 (0.37)	29	-0.01 (0.54)	-0.02 (-0.55 to 0.51)
Looney and Raynor,[37] 2014	3	6 (0)	7	-0.16 (0.48)	8	-0.07 (0.61)	-0.16 (-1.18 to 0.85)
Wake et al,[63] 2013	3	12 (0)	56	-0.20 (0.50)	49	-0.10 (0.36)	-0.23 (-0.61 to 0.16)
Taveras et al,[58] 2015	1	12 (0)	164	-0.09 (0.33)	171	-0.04 (-0.32)	-0.16 (-0.52 to 0.21)
McCallum et al,[39] 2007	1	15 (12)	70	0 (0.61)	76	0.02 (0.55)	-0.03 (-0.36 to 0.29)
Outcome: BMI							
Taveras et al,[57] 2011	3	12 (0)	253	0.30 (1.4)	192	0.50 (1.4)	-0.13 (-0.47 to 0.21)
van Grieken et al,[60] 2013	2	24 (12)	277	1.4 (1.5)	230	1.4 (1.7)	-0.04 (-0.27 to 0.18)
Wake et al,[62] 2009	1	12 (9)	127	0.60 (2.6)	115	0.70 (2.2)	-0.04 (-0.29 to 0.21)
Outcome: BMI percentile							
Resnicow et al,[48] 2015[a]	3	24 (0)	154	-4.9 (15.2)	158	-1.8 (13.8)	-0.21 (-0.49 to 0.07)
Outcome: Weight							
Kong et al,[35] 2013	4	9 (0)	28	1.7 (4.0)	23	2.5 (4.3)	-0.19 (-1.08 to 0.69)
Subtotal (I^2 = 0.0%; P = .91)							-0.17 (-0.25 to -0.08)



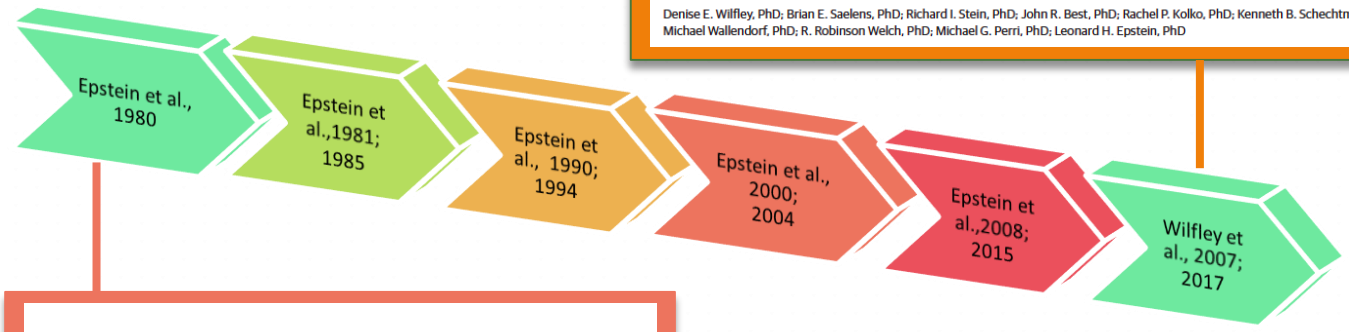
U.S. Preventive Services TASK FORCE

Longer treatment duration and greater number of treatment sessions are associated with more positive results

O'Connor et al., 2017, *JAMA*

FAMILY-BASED TREATMENT (FBT): A TIME-TESTED APPROACH

1980



JAMA Pediatrics | Original Investigation

Dose, Content, and Mediators of Family-Based Treatment for Childhood Obesity
A Multisite Randomized Clinical Trial

Denise E. Wilfley, PhD; Brian E. Saelens, PhD; Richard I. Stein, PhD; John R. Best, PhD; Rachel P. Kolko, PhD; Kenneth B. Schechtman, PhD; Michael Wallendorf, PhD; R. Robinson Welch, PhD; Michael G. Perri, PhD; Leonard H. Epstein, PhD

Journal of Pediatric Psychology, Vol 5, No. 1, 1980

Comparison of Family-Based Behavior Modification and Nutrition Education for Childhood Obesity[1]

Leonard H. Epstein,[2] Rena R. Wing, Linda Steranchak, Barbara Dickson, and Joyce Michelson
Western Psychiatric Institute and Clinic and Children's Hospital of Pittsburgh, University of Pittsburgh School of Medicine

Present

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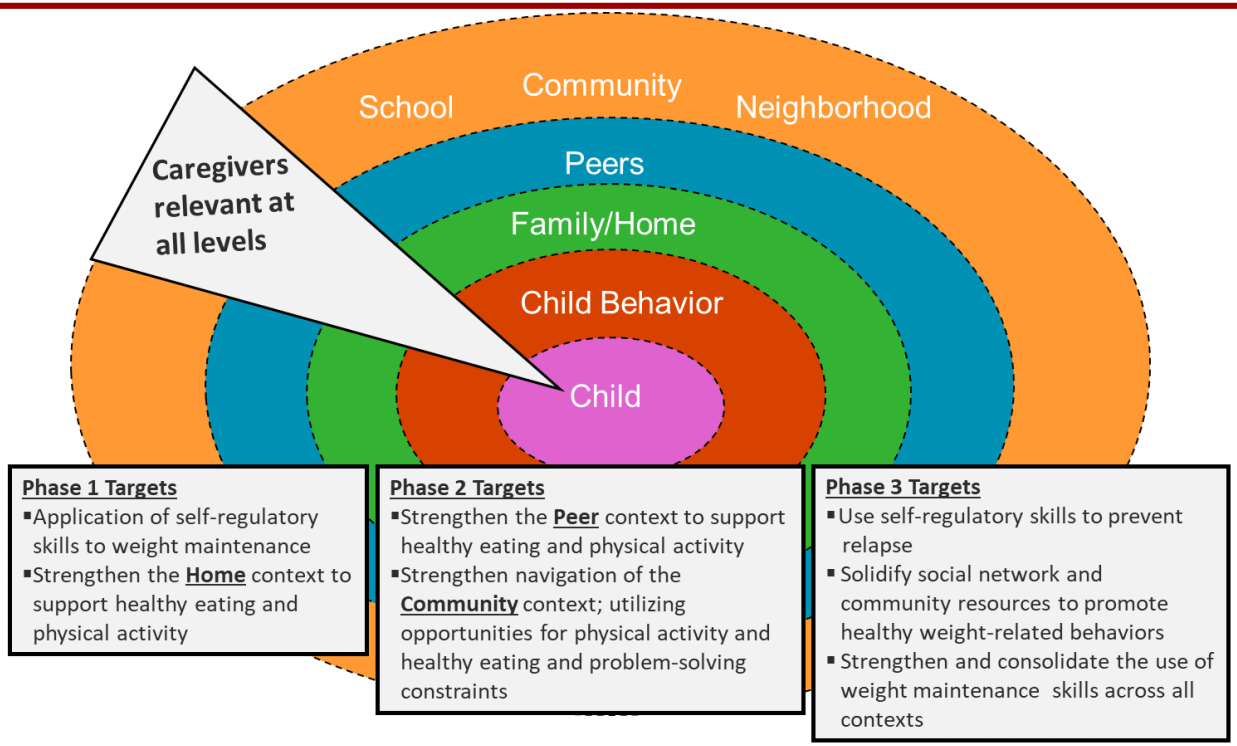
FBT TREATMENT

- Targets lifestyle behaviors in both youth and caregivers
- Recognizes that knowledge alone is not sufficient
- Focuses on successive changes using family support
- Core strategies include: positive parenting, self-monitoring, reinforcement, and stimulus control
- Shown to impact: overweight, physical and psychosocial health (e.g., blood pressure, cholesterol, insulin sensitivity)
- More cost-effective than treating parent and child separately

ENHANCED SOCIAL FACILITATION MAINTENANCE (SFM+)



Phase 1 Targets
- Application of self-regulatory skills to weight maintenance
- Strengthen the **Home** context to support healthy eating and physical activity

Phase 2 Targets
- Strengthen the **Peer** context to support healthy eating and physical activity
- Strengthen navigation of the **Community** context; utilizing opportunities for physical activity and healthy eating and problem-solving constraints

Phase 3 Targets
- Use self-regulatory skills to prevent relapse
- Solidify social network and community resources to promote healthy weight-related behaviors
- Strengthen and consolidate the use of weight maintenance skills across all contexts

Wilfley et al., 2010, *Obesity*

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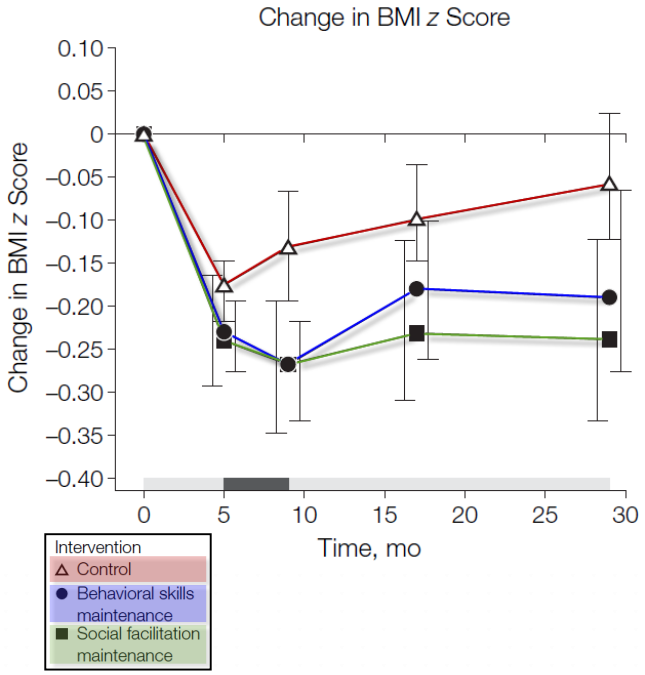
CHILDHOOD OBESITY REQUIRES SUSTAINABLE, LONG-LASTING TREATMENT



- Family-based intervention
- First large-scale weight loss maintenance study in children
- Social facilitation approach produced significantly greater:
  - Weight loss maintenance
  - Psychosocial improvements
- Parent success is associated with child long-term success

Wilfley et al., 2007, *JAMA*; Goldschmidt et al., 2011, *Pediatr*

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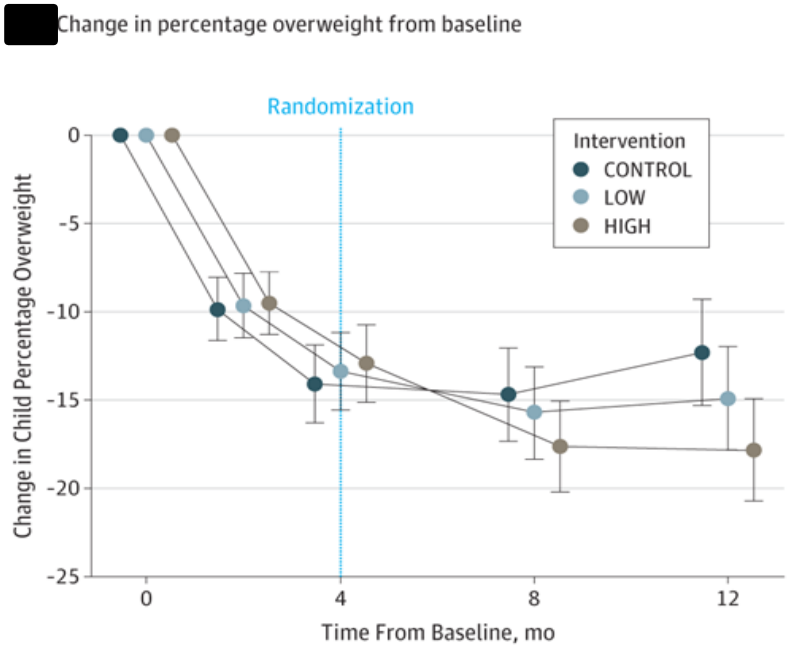
DOSE, CONTENT, AND MEDIATORS OF FBT

- SFM+ High greater weight loss maintenance than SFM+ Low (p=.02)
- SFM+ High and Low both yielded significantly greater weight loss maintenance than Control (p<.001 and p=.02, respectively)
- Behavioral and socio-environmental components mediated outcomes



Wilfley et al., 2017, *JAMA Pediatr*

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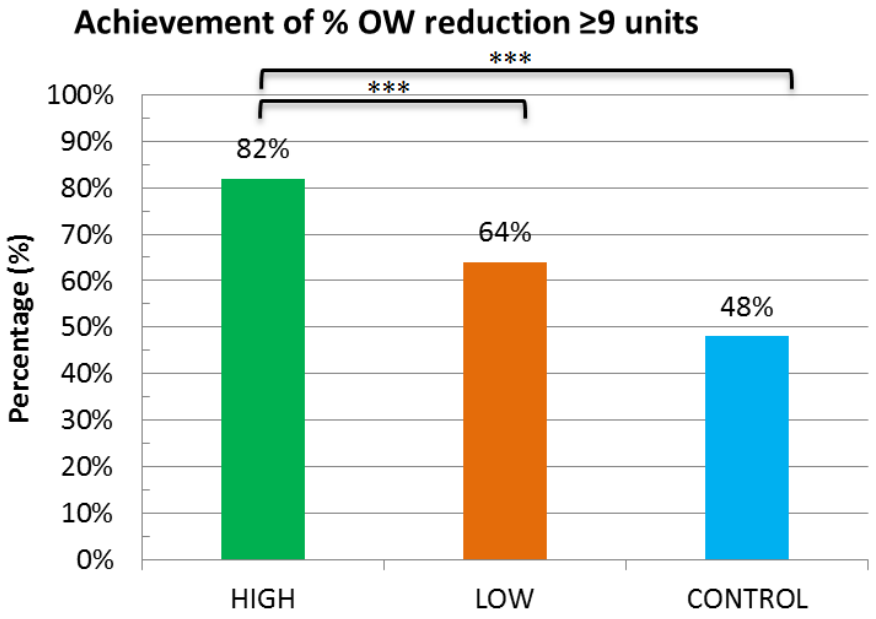
SFM PRODUCES HIGHER RATES OF CLINICALLY SIGNIFICANT OUTCOMES



- A reduction of ≥9 units in percent overweight improves body composition and metabolic risk factors
- SFM⁺ High yielded significantly greater achievement of clinically significant reductions in %OW than SFM⁺ Low (NNT = 5.56; *p*=.03) and Control (NNT = 2.94; *p*<.001)

***p<.001

Wilfley et al., 2017, *JAMA Pediatr*

Ford et al., 2010, *Arch Dis Child*; Reinehr et al., 2004, *Arch Dis Child*

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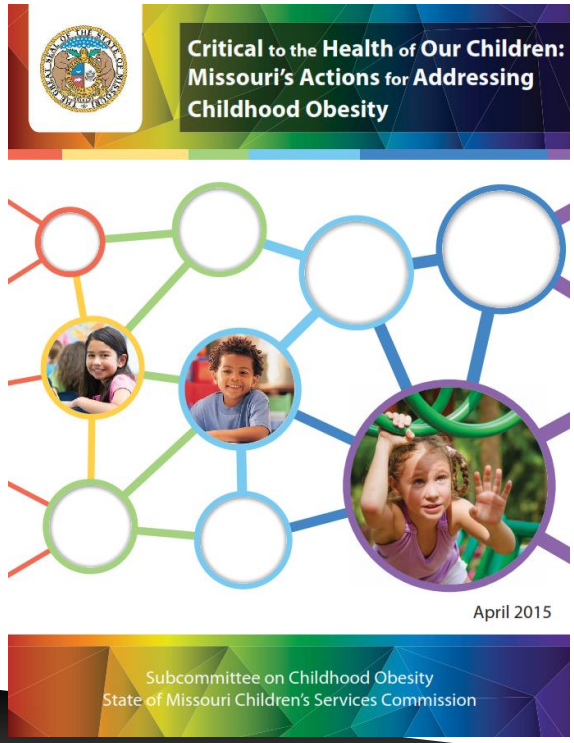
Benefits of a Family-Based Behavioral Treatment

- Demonstrated effectiveness for youth with obesity
- Provides concurrent treatment for parent with obesity and can generalize to other family members
- More cost effective than separate treatment of parent and child with obesity
- Can be individualized and produces positive psychosocial benefits
- Can be implemented with 2-18 years of age and in diverse settings like primary care
- Family-based interventions can be used to treat: obesity in multiple family members, obesity and comorbidities in multiple family members, and obesity in the parent and prevention of obesity in youth

Conclusions

- FBT is a robust, evidence-based intervention
- High-dose extended care treatment, using a family-based socio-environmental approach, produced superior rates of clinically significant outcomes and maintenance of relative body weight, suggesting the importance of:
  - Improving the shared home environment and building healthy routines
  - Harnessing parental and peer support for maintenance of healthy changes
  - Promoting positive body esteem and coping with teasing
  - Building opportunities for practicing new behaviors across multiple settings and contexts beyond the intervention setting
- Provides concurrent treatment for the parent/caregiver with obesity and has the potential to generalize to other family members

Missouri's Call to Action



Subcommittee Actions

- Created 5 draft recommendations
  - Prevention (child care)
  - Prevention (schools)
  - Treatment (family-based behavioral treatment)
  - Coordination between prevention and treatment (state centers of excellence)
  - Commission on child health and wellness (coordinating council)

http://extension.missouri.edu/mocan/childhoodobesity/

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A Reimbursement Pathway for Access to USPSTF-Recommended Obesity Care

- MO Medicaid obesity treatment benefit became effective September 1, 2021 for Fee-For-Service. Managed Care services to follow in Summer, 2022. **Reimbursement matches the USPSTF recommendations**.

13 CSR 70-25.140 Biopsychosocial Treatment of Obesity for Youth and Adults

PURPOSE: This rule establishes the MO HealthNet payment policy for the biopsychosocial treatment of obesity for youth and adult participants. The goal of this policy is to improve health outcomes for both the youth and adult population by managing obesity and associated co-morbidities.

MO Medicaid Rules https://www.sos.mo.gov/CMSImages/AdRules/moreg/2018/v43n17Sept4/v43n17a.pdf
https://www.sos.mo.gov/cmsimages/adrules/csr/current/13csr/13c70-25.pdf

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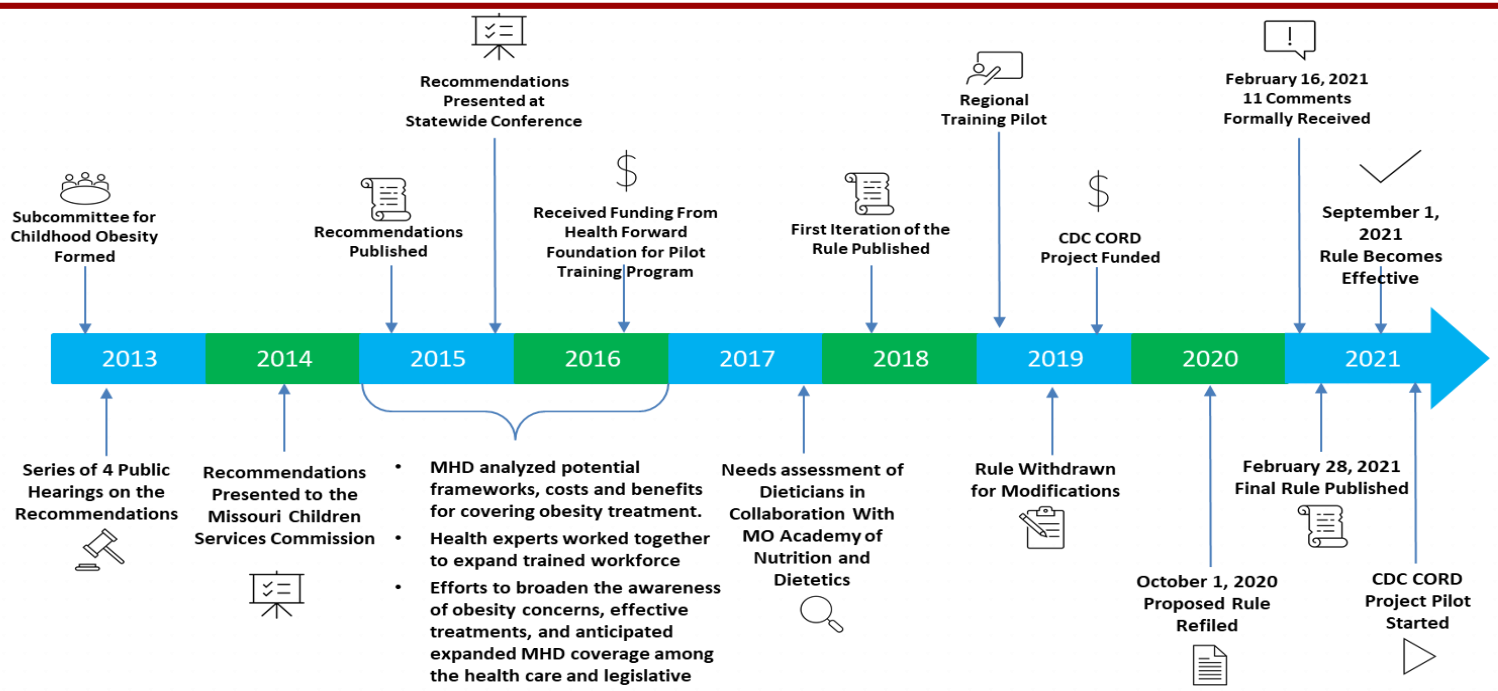
Timeline Synopsis for Medicaid Rule 2013-2022



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Highlights of the Obesity Treatment

Services

- **Youth:** Family Based Behavioral Therapy (FBT)-26 hours
- **Adults:** Intensive Behavioral Therapy (IBT)-12 hours
- **Medical Nutrition Therapy (MNT):** All participants-1 hour and 45 minutes
- Delivered through mix of individual, family (child), and group sessions
- **6 month intervention period** with continuation criteria

Participant Criteria

- **Medical provider** diagnosis of obesity and referral for FBT/IBT & MNT
- **Youth**, ages 0 through 20, with age- and gender-specific BMI ≥95th%
- **Adults**, 21 years and older with BMI ≥30

Providers

- **FBT & IBT:** Individual and group sessions: psychiatrist, clinical social worker, psychologist, professional counselor, marriage and family therapist, and psychiatric advanced practice registered nurse. Group sessions only: registered dietitian/nutritionist
- **MNT:** Registered dietitian/nutritionist
- **All providers** must be licensed and have specialist certificate or meet experience & training criteria

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Maria's Story

Age 7

- 168 lbs
- Told she was just going through a growth spurt by pediatrician
- Mother felt blamed and concerned about daughter's weight since she and her husband also struggle with their weight

Age 12

- 398 lbs
- Suffered unbearable stigmatization at school
- Maria and her mother completed programs together that were geared either toward adults or children, except for one which included the entire family but was not of sufficient duration

Age 14

- 443 lbs; BMI 63.6
- Gastric bypass surgery was her only option after spending countless dollars out-of-pocket on ineffective, insufficient, or non-evidence based programs

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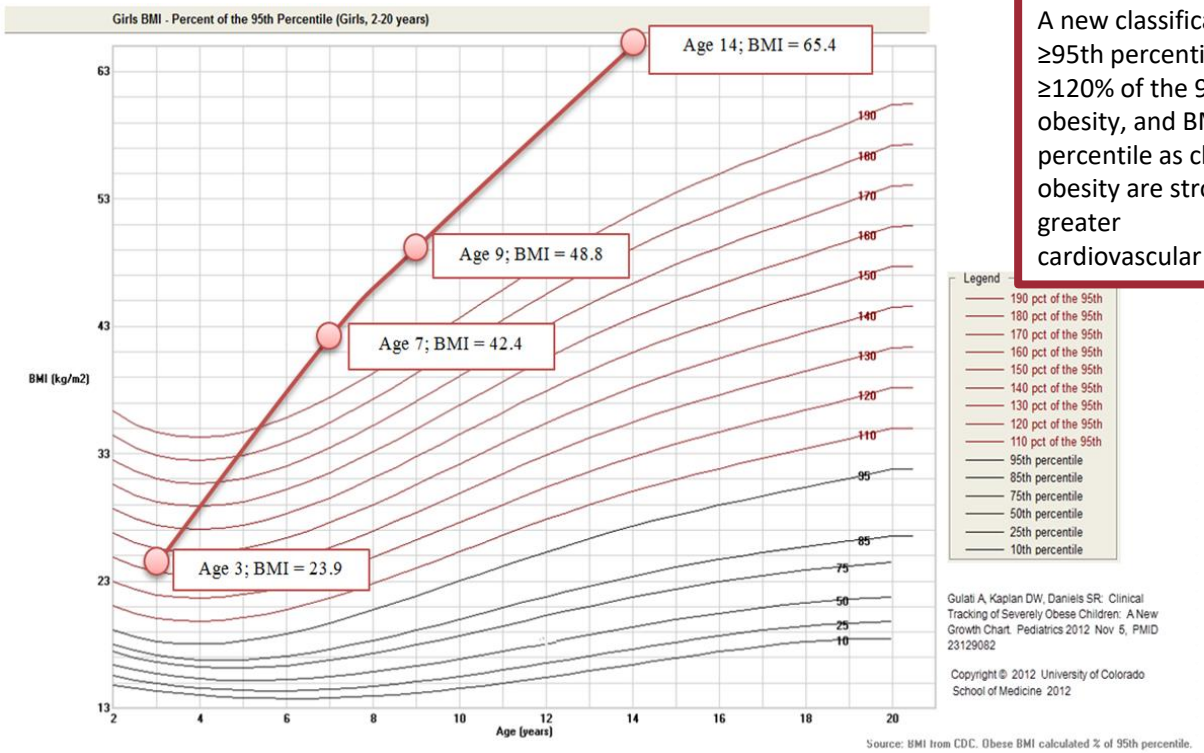
Maria's Growth Chart



A new classification system recognizes BMI ≥95th percentile as **class I** obesity, BMI ≥120% of the 95th percentile as **class II** obesity, and BMI ≥140% of the 95th percentile as class III obesity. Class II and III obesity are strongly associated with greater cardiovascular and metabolic risk.

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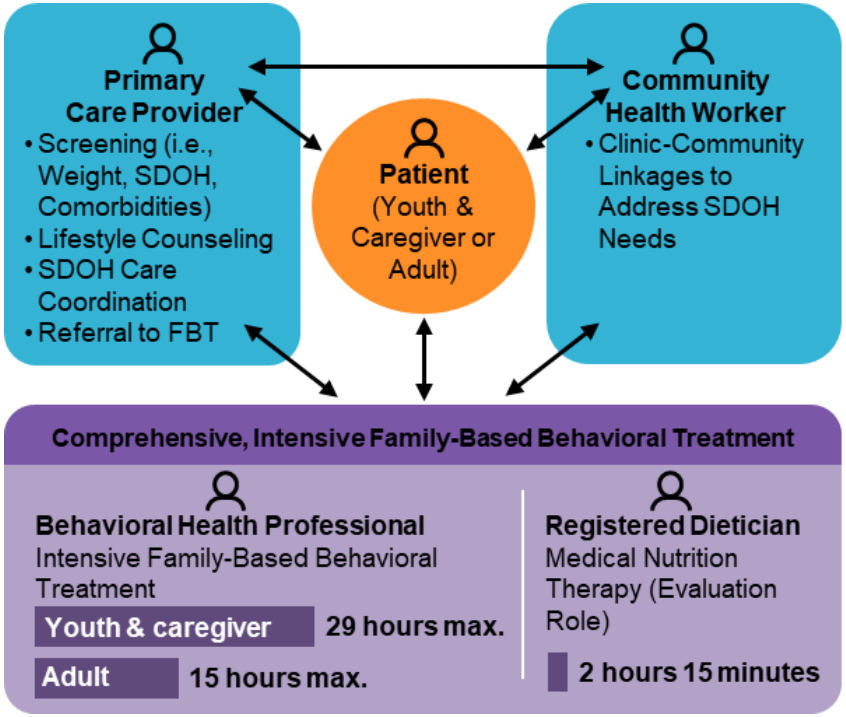
OVERVIEW OF THE MISSOURI OBESITY TREATMENT PACKAGE



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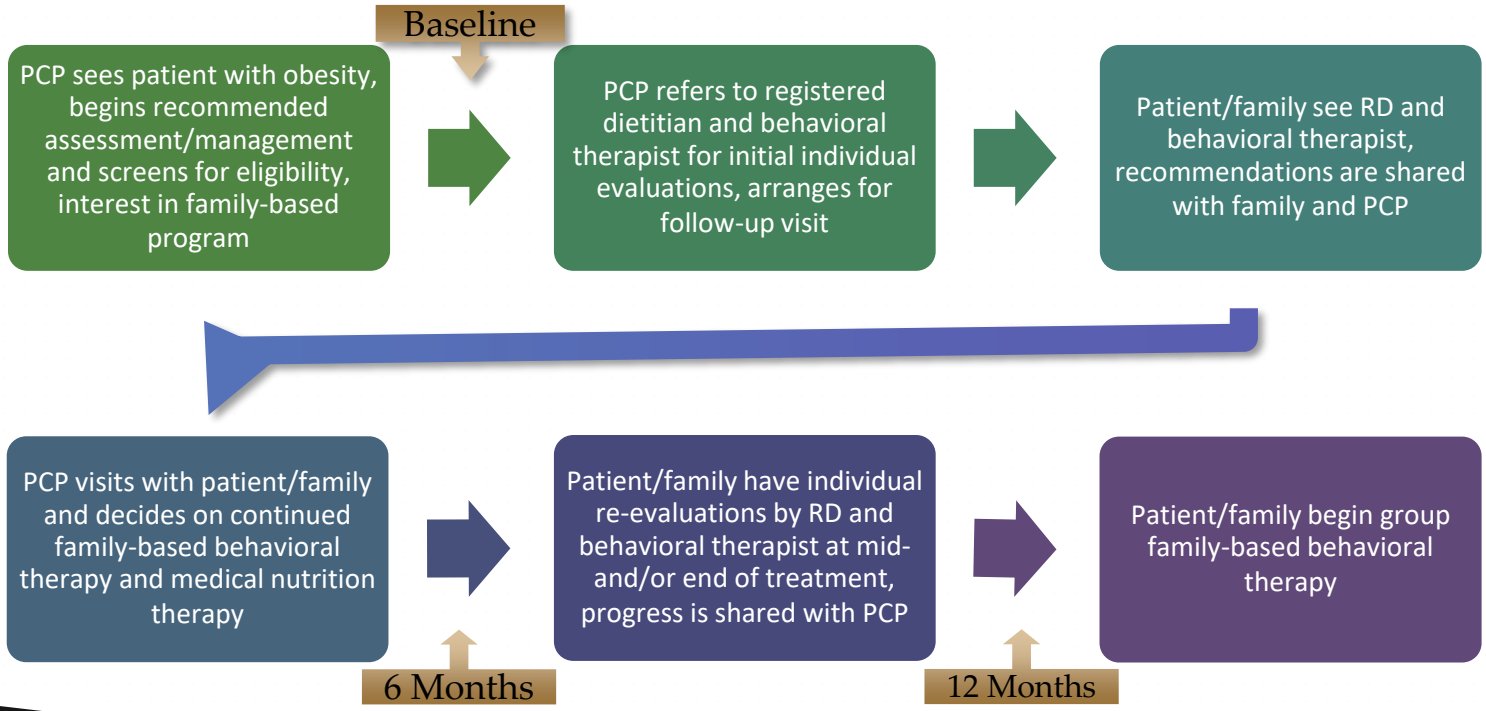
MHD'S PEDIATRIC OBESITY TREATMENT: HOW WILL IT *IDEALLY* WORK?



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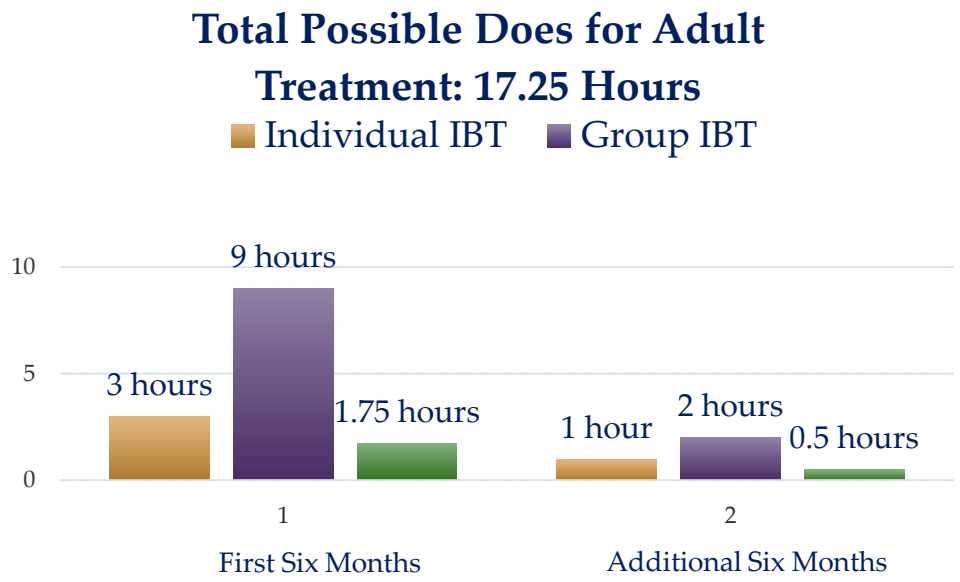
MHD'S ADULT OBESITY TREATMENT PACKAGE ELEMENTS

- Available to adults who meet the eligibility criteria
- IBT can be delivered face-to-face or via telehealth
- The additional 6 months of treatment require prior authorization
- Adults who are ineligible for the additional 6 months can re-enroll next year



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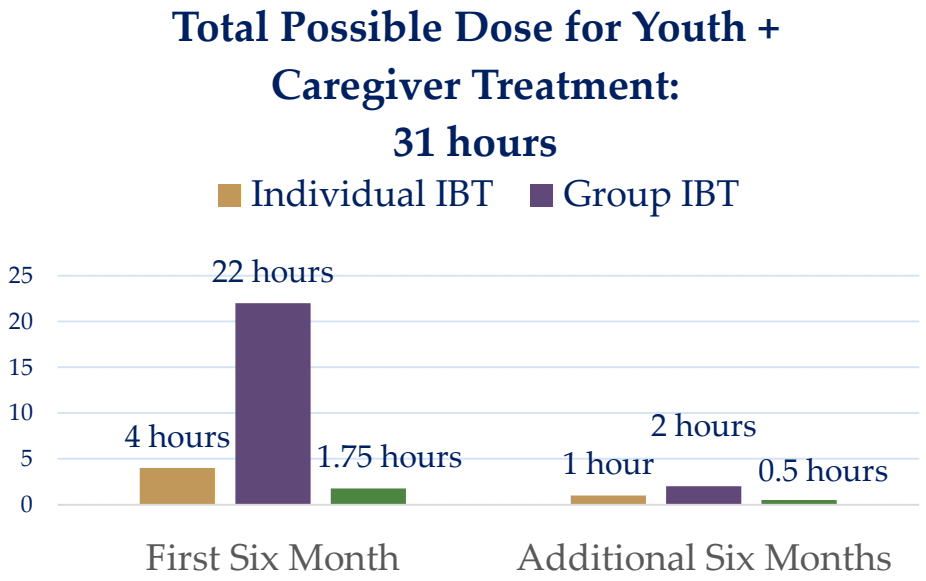
MHD'S YOUTH + CAREGIVER OBESITY TREATMENT PACKAGE ELEMENTS

- Youths ≤20 years old with Obesity
- IBT can be delivered face-to-face or via telehealth
- The additional 6 months of treatment require prior authorization
- Youths who are ineligible for the additional 6 months can re-enroll next year



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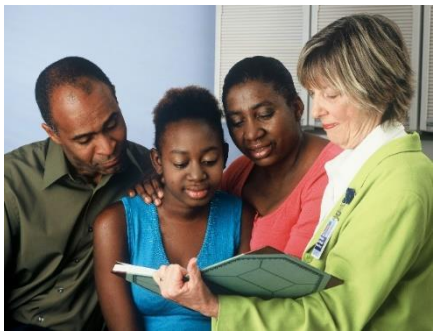
REFERRAL AND CARE COORDINATION



QUALIFICATIONS TO PROVIDE MNT

- Licensed registered dietitian or registered dietitian/nutritionist (RDN) enrolled as a MO HN provider, and
- Has a national specialist certificate for obesity treatment in adults or children/adolescents (from Academy of Nutrition and Dietetics), or
- Has completed a qualified training program addressing obesity treatment
- RD/RDN may qualify based on experience if has:
  - Maintained a dietitian license credential for a minimum of two (2) years, and
  - A minimum of 2,000 hours of specialty practice experience delivering weight management behavioral treatment for individuals and/or families or youth within the past 5 years; and
  - Documentation of a minimum of 6 hours of obesity or weight management CEUs or professional equivalent post receipt of license credential

QUALIFICATIONS TO PROVIDE IBT/FBT

- Licensed behavioral health professional: social worker, marriage/family therapist, professional counselor, psychologist, psychiatric NP, psychiatrist
- Registered dietitians are eligible to provide group IBT
- Have a specialist certification for the participant population(s) served that was attained through completion of a qualified training program addressing obesity and weight management treatment
- A licensed provider may provide IBT without a certificate if the provider has:
  - Maintained 1 of the above license credentials for a minimum of two 2 years
  - Minimum of 2,000 hours of specialty practice experience delivering weight management behavioral treatment for individuals and/or families or youth within the past 5 years; and
  - Documentation of a minimum of 6 hours of obesity or weight management CEUs or professional equivalent post receipt of license credential

FBT/IBT TRAINING PROGRAM CONTENT REQUIREMENTS

- Qualified Training Program:
  - Content-expert instruction and interactive discussion (which may occur face-to-face or by electronic delivery);
  - Course materials developed by professionals with demonstrated expertise in the content area
  - Content areas cover evidence-based approaches to effectively deliver weight management and obesity treatment for adult and/or youth participants using a family-centered, comprehensive approach; and sponsored by or conducted in affiliation with a qualified university
- The training program for youth and adults participants shall contain a mix of didactics with simulation work conducted by members of the training center staff
- The qualified training program shall provide a certificate upon completion of the program

FBT/IBT TRAINING PROGRAM CERTIFICATION RENEWAL PROCESS

- Initially, the provider is certified for one (1) year. Renewal of specialist certification will not be issued until the new provider receives documentation of compliance with certification standards
- Qualified training programs will provide a means for newly certified providers to receive evaluation of compliance with certification standards using established procedures
- This one-time documentation will occur within the first year of completing the qualified training program. Evaluations of compliance may be conducted in small groups or individually and include case reviews plus audio-recordings of the treatment delivered by the newly certified provider
- Newly trained providers will have a sample of session audio recordings evaluated (i.e., an initial treatment session, and additional review of audio recordings at the beginning, middle, and final phases of treatment) within the first six (6) months of providing services
- If the newly certified provider is unable to meet competency the experienced evaluator provides corrective feedback. The experienced provider also reviews additional session audio recordings until two (2) consecutive recordings receiving a competent rating

OBESITY TREATMENT WORKFORCE DEVELOPMENT TO DATE

- 2016-2019: Grant-funded trainings of behavioral health professionals to provide family-based behavioral treatment; RD/RDNs to provide medical nutrition therapy for children in Kansas City area
- 2018-present: Dr. Wilfley and colleagues have trained St. Louis and mid-MO behavioral health professionals in pediatric primary care clinics in FBT through PCORI grant
- 2019-present: Dr. Wilfley and colleagues have trained behavioral health professionals in a Joplin and Kansas City pediatric primary care clinic through CDC grant
- Have partnered with MO AAP and MO AND to provide trainings for pediatricians and RDs/RDNs seeing children
- Partnering with Show-Me Telehealth Network in pediatric weight mgmt ECHO

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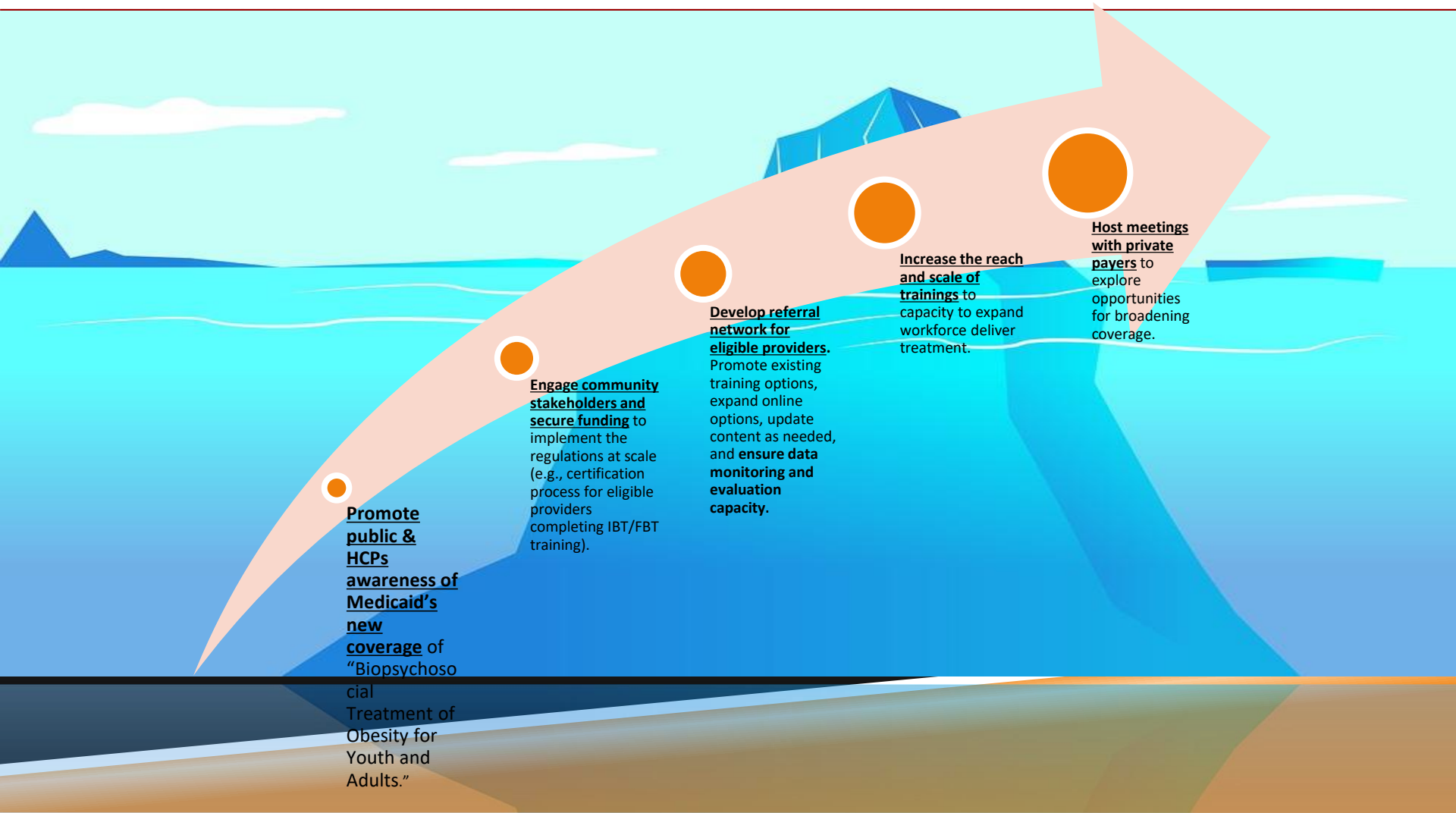
PRIORITIES FOR SCALING UP FBT TO BRIDGE THE GAPS



THANK YOU!

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QUESTIONS?

MEDICAID.GOV – RELEVANT SUPPLEMENTAL INFORMATION

- For children enrolled in Medicaid, the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit covers all medically necessary services which can include obesity-related services. For adults, the states can choose which services to provide, with most states choosing to cover at least one obesity treatment.
- The Affordable Care Act includes several provisions that promote preventive care including obesity-related services and coverage.
- The law calls for states to design public awareness campaigns to educate Medicaid enrollees on the availability and coverage of preventive services, including obesity-related services. To help states meet this requirement, the Centers for Medicare & Medicaid Services (CMS) will host calls and webinars regarding coverage and promotion of preventive services, develop fact sheets that address Medicaid coverage of preventive services, and share examples of state Medicaid program efforts to increase awareness of preventive services
- The Affordable Care Act provided funding for the Childhood Obesity Demonstration Project. The Children's Health Insurance Program Reauthorization Act (CHIPRA) established this obesity demonstration grant program to identify effective health care and community strategies to support children's healthy eating and active living to help combat childhood obesity. The project targets low-income children aged 2-12 years. The Centers for Disease Control and Prevention (CDC) leads this program and is working with the Centers for Medicare and Medicaid Services (CMS), Health Resources and Services Administration (HRSA), and the National Institutes of Health (NIH).

MHD'S ADULT OBESITY TREATMENT CONTINUATION CRITERIA

Eligible for Additional 6 Months

- ☑ Reduction of 5% body weight
- ☑ If the patient is found to have a relevant medical diagnosis and *is treated for it*.

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MHD'S YOUTH AND CAREGIVER OBESITY TREATMENT CONTINUATION CRITERIA

Eligible for Additional 6 Months

The youth participant meets the lesser of one of the following:

- ☑ BMI decreases below 95th percentile
- ☑ Reduction in 5% body fat
- ☑ Weight Stabilization (defined as ± 0.5 BMI units
- ☑ If the participant's initial BMI >99th percentile, a decrease in 9 units of percentage

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MHD Update

Presented By:

Jessie Dresner

CCBHOs

Presented By:

Jennifer Bax

Jennifer Johnson

Certified Community Behavioral Health Organizations (CCBHO)

Expansion in Missouri

Jessica Bounds, Director of Community Treatment Programming

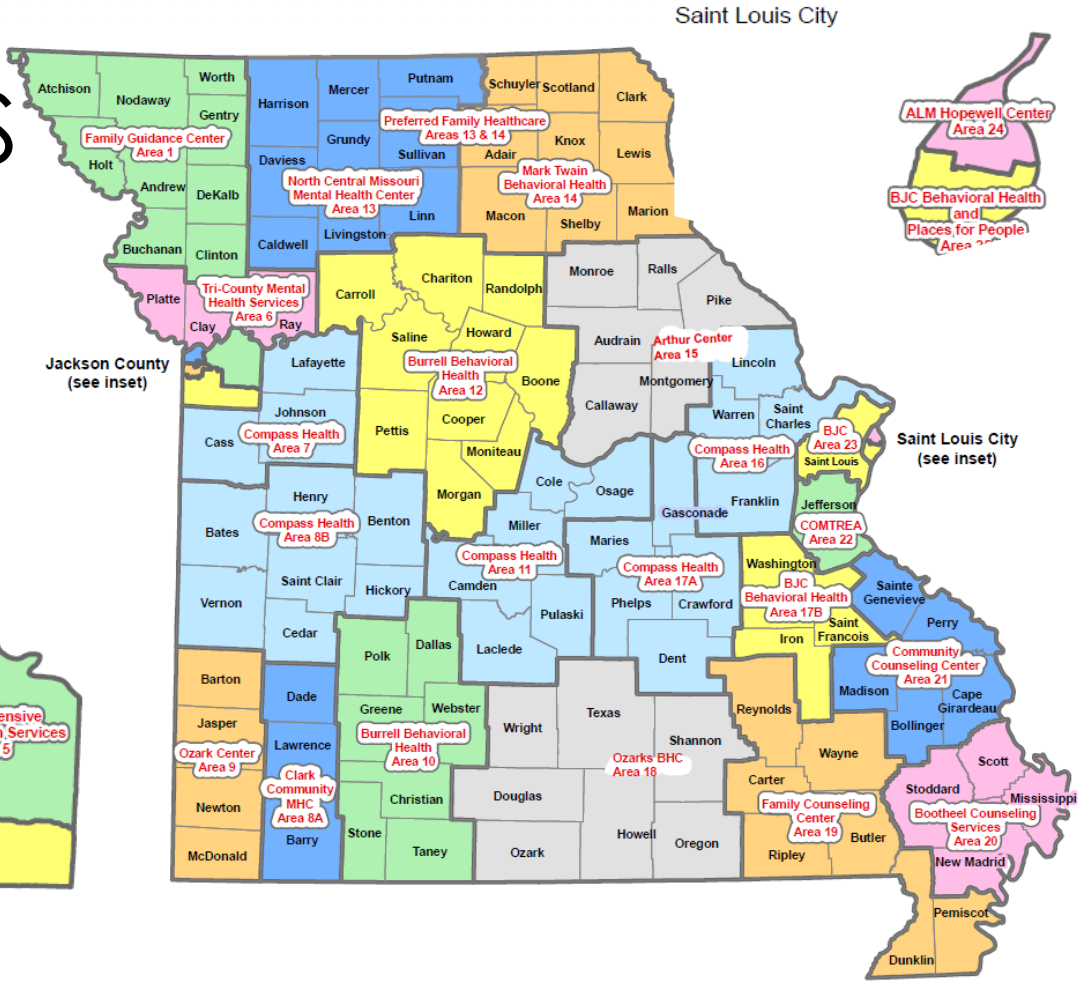
Jennifer Bax, Program Coordinator

CCBHOS IN MISSOURI

Burrell Behavioral Health	Clark Community Mental Health Center	Compass	Comprehensive Mental Health Services	COMTREA	Family Counseling Center
Family Guidance Center	Mark Twain Behavioral Health	North Central Mental Health Center	Ozark Center	Places for People	Preferred Family Healthcare
ReDiscover	Tri-County Mental Health Services	Arthur Center	BJC	Bootheel Counseling	Community Counseling Center
Hopewell	University Health	Ozark BHC			

REGULATIONS

- All CCBHOs must be certified by the DBH and are regulated by 9CSR 30-6.010 Certified Community Behavioral Health Organizations.



OBJECTIVES

CCBHOs integrate behavioral health with physical healthcare.

- Crisis Intervention
- Screening
- Treatment
- Prevention
- Wellness Services

REQUIREMENTS

CCBHOs are required to:

USE EVIDENCE BASED PRACTICES & PROMISING PRACTICES

COORDINATE CARE & PROVIDE AN ARRAY OF SERVICES

SERVE THE POPULATION OF FOCUS WITH THEIR GEOGRAPHIC SERVICE AREA

PROVIDE NEEDED SERVICES TO THE POPULATIONS OF FOCUS REGARDLESS OF PAYMENT SOURCE OR ABILITY TO PAY

MEASURE & REPORT OUTCOMES ON EFFICIENCY & EFFECTIVENESS OF SERVICES PROVIDED AND HEALTH STATUSES

SERVICES

The comprehensive array of behavioral health services must include:

- Crisis Mental Health Services
- Screening, Assessment, & Diagnosis
- Patient Centered Treatment Planning
- Outpatient Mental Health & SUD Services
- Primary Care Screening & Monitoring
- Psychiatric Rehabilitation
- Peer & Family Support Services

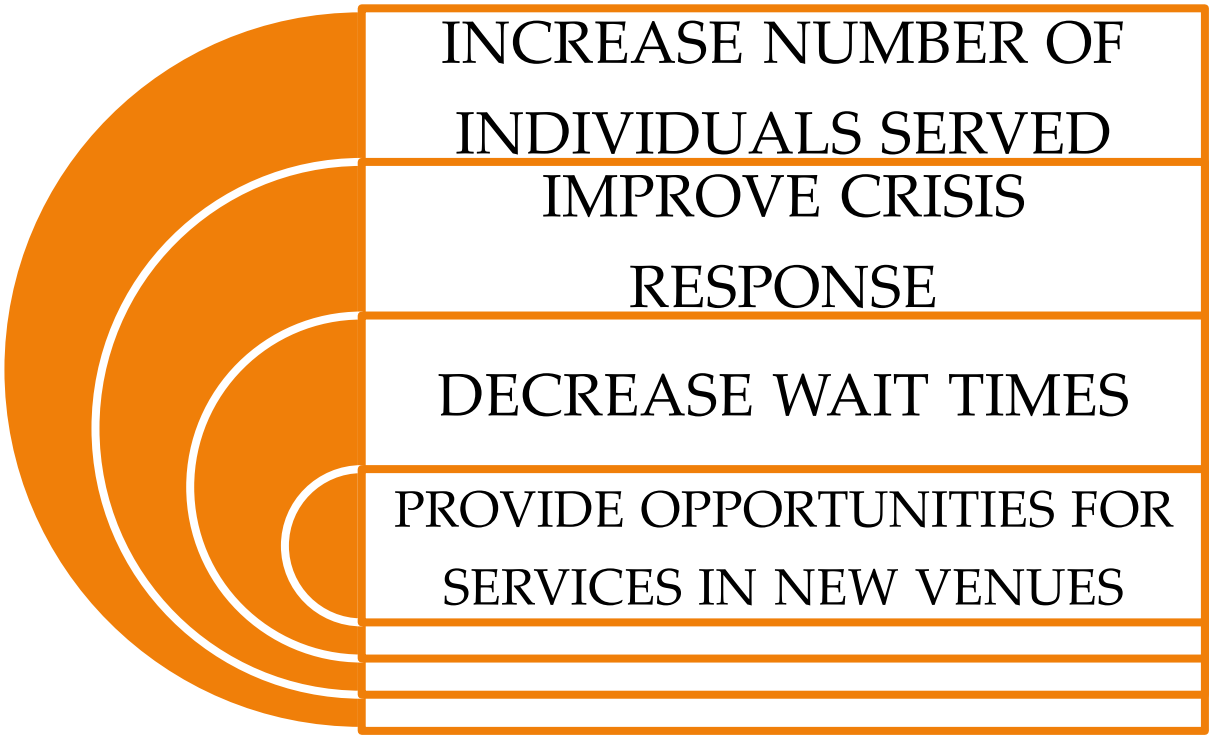
REQUIRED STAFF

CCBHOs are required to have the following staff:

- MEDICAL DIRECTOR WHO IS A LICENSED PSYCHIATRIST
- LICENSED MENTAL HEALTH PROFESSIONALS WITH EXPERTISE & TRAINING IN TRAUMA RELATED DISORDERS
- COMMUNITY BEHAVIORAL HEALTH LIAISON
- CLINICAL STAFF TO COMPLETE ASSESSMENTS AND TREATMENT PLANS
- LICENSED MHP WITH TRAINING ON EVIDENCE-BASED, BEST AND PROMISING PRACTICES AS DMH REQUIRES
- PHYSICIAN(S) WITH A WAIVER
- STAFF WHO HAVE BEEN WELLNESS TRAINED
- INDIVIDUALS WHO HAVE COMPLETED DEPARTMENT-APPROVED SMOKING CESSATION TRAINING
- FAMILY SUPPORT PROVIDERS
- CERTIFIED PEER SPECIALISTS

BENEFITS

Initial outcomes indicate that CCBHOs:



Missouri Department of SOCIAL SERVICES

MoHealthNet

Asthma Policy Update

Joshua Moore, PharmD
MO HealthNet Director of Pharmacy
March 22, 2022

Asthma Treatment

- Asthma can be effectively treated, and most patients can achieve good control of their asthma. When asthma is under good control, patients can:
  - Avoid troublesome symptoms during day and night
  - Need little to no reliever medication
  - Have productive, physically active lives
  - Have normal or near normal lung function
  - Avoid serious asthma flare-ups (exacerbations or attacks)
- Treatment with inhaled corticosteroid (ICS) containing medications reduces frequency and severity of asthma symptoms and reduces the risk of flare-ups and dying due to asthma.
- Asthma flare-ups can be fatal. They are more common and more severe when asthma is uncontrolled.

References:
1. GINA Pocket Guide 2021 - https://ginasthma.org/wp-content/uploads/2021/05/GINA-Pocket-Guide-2021-V2-WMS.pdf

Asthma Treatment Recommendations

- For safety, the Global Initiative for Asthma (GINA) recommends that every adult and adolescent with asthma should receive an ICS-containing controller medication to reduce risk of serious exacerbations, including patients with infrequent symptoms.
- Every patient with asthma should have a reliever inhaler for as-needed use:
  - ICS-formoterol or short acting beta agonist (SABA)
  - ICS-formoterol is preferred as it reduces the risk of severe exacerbations compared to SABA
  - ICS-formoterol should not be used as the reliever when the patient is taking a different maintenance ICS-LABA, these patients should receive a SABA

References:
1. GINA Pocket Guide 2021 - https://ginasthma.org/wp-content/uploads/2021/05/GINA-Pocket-Guide-2021-V2-WMS.pdf

SABA Overutilization

- Although SABA provides quick relief of symptoms, SABA-only treatment is associated with increased risk of exacerbations and lower lung function.
- Regular use of SABA increases allergic responses and airway inflammation and reduces the bronchodilator response to SABA when it is needed.

- Use of ≥3 canisters per year is associated with an increased risk of severe exacerbations.
  - 40.5% of MO HealthNet participants that received at least 1 SABA in 2021 received 3 or more in 12 months.
- Use of ≥ 12 canisters in a year is associated with increased risk of asthma-related death.
  - 6.4% of MO HealthNet participants that received at least 1 SABA in 2021 received 12 or more in 12 months.

References:
1. GINA Pocket Guide 2021 - https://ginasthma.org/wp-content/uploads/2021/05/GINA-Pocket-Guide-2021-V2-WMS.pdf

SABA Utilization by MHD Participants

# of Participants who received at least one SABA MDI in CY 2021		
18 And Under	Over 18	Grand Total
48,854	46,931	95,785

>4 MDI/Year	18 And Under	Over 18	Grand Total
Asthma	3,456	1,582	5,038
Both	33	926	959
COPD	27	7,443	7,470
None	4,626	5,371	9997
Grand Total	**8,142**	**15,322**	**23,464**
	17%	33%	24%

>6 MDI/Year	18 And Under	Over 18	Grand Total
Asthma	2,118	1,126	3,244
Both	22	751	773
COPD	16	5,619	5,635
None	2,607	3,644	6,251
Grand Total	**4,763**	**11,140**	**15,903**
	10%	24%	17%

>10 MDI/Year	18 And Under	Over18	Grand Total
Asthma	855	548	1,403
Both	10	432	442
COPD	6	3,079	3,085
None	977	1,659	2,636
Grand Total	**1,848**	**5,718**	**7,566**
	4%	12%	8%

>12 MDI/Year	18 And Under	Over 18	Grand Total
Asthma	521	317	838
Both	6	256	262
COPD	4	1,565	1,569
None	575	791	1,366
Grand Total	**1,106**	**2,929**	**4,035**
	2%	6%	4%

Figures are for CY2021 and exclude participants diagnosed with cystic fibrosis

ER and Inpatient Stays for Asthma or COPD Exacerbation per Participant per Year

	18 and Under				Over 18			
# of MDIs	>11	>6	>3	<3	>11	>6	>3	<3
Asthma	0.527	0.529	0.437	0.220	0.490	0.420	0.379	0.229
Both	0.900	0.818	0.725	0.579	1.227	1.191	1.094	0.803
COPD	0.500	0.375	0.206	0.049	0.495	0.450	0.440	0.330
None	0.034	0.040	0.044	0.026	0.023	0.021	0.023	0.021
Total	0.268	0.263	0.203	0.067	0.421	0.357	0.316	0.109

Data pulled 3/17/2022 for dates of service in CY 2021. Excludes participants diagnosed with CF. Analysis include participants who received 1 albuterol MDI in CY 2021. ER and Inpatient claims included if the claim included diagnosis code of asthma exacerbation, status asthmaticus, or COPD exacerbation.

MHD Compared to other Medicaid Programs

PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate: Age 40 and Older (FFY 2020)

Learn more about this measure +

Rate

- Inpatient Hospital Admissions for Chronic Obstructive Pulmonary Disease (COPD) or Asthma per 100,000 Beneficiary Months: Ages 40 to 64

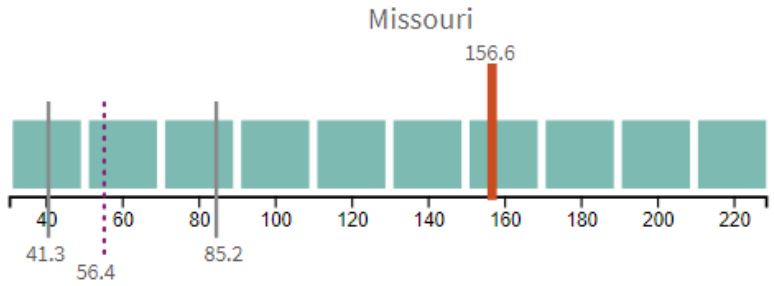
Population

Medicaid & CHIP

31 States Reporting

156.6 State Rate

Rate per 100,000 Beneficiary Months



Rate per 100,000 Beneficiary Months
Drag left or right to move the scale. Zoom in or out by placing your cursor over the graph and scrolling or double clicking.

Lower rates are better for this measure

PQI 15: Asthma in Younger Adults Admission Rate: Ages 18 to 39 (FFY 2020)

Learn more about this measure +

Rate

- Inpatient Hospital Admissions for Asthma per 100,000 Beneficiary Months: Ages 18 to 39

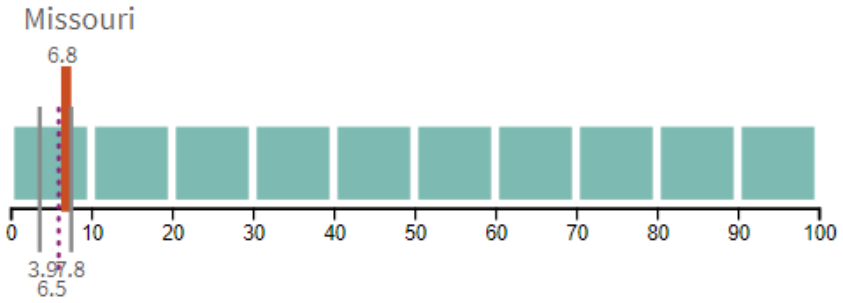
Population

Medicaid & CHIP

32 States Reporting

6.8 State Rate

Rate per 100,000 Beneficiary Months



Rate per 100,000 Beneficiary Months
Drag left or right to move the scale. Zoom in or out by placing your cursor over the graph and scrolling or double clicking.

Lower rates are better for this measure

References:

1. https://www.medicaid.gov/state-overviews/stateprofile.html?state=missouri

MHD Compared to other Medicaid Programs

Asthma Medication Ratio: Ages 5 to 18
(FFY 2020)

Visit this measure on: Medicaid & CHIP SCORECARD

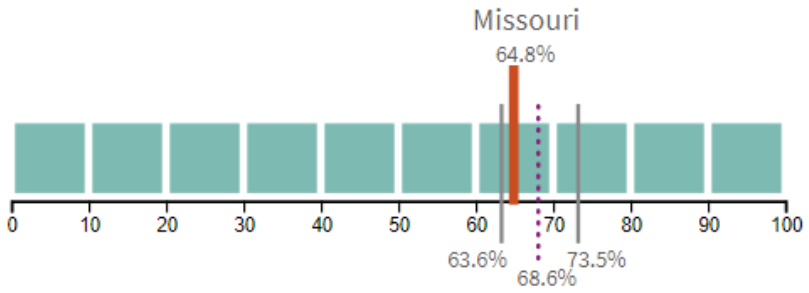
Learn more about this measure +

Rate: Select One

- Percentage with Persistent Asthma who had a Ratio of Controlle…

Population
Medicaid & CHIP

43 States Reporting **64.8%** State Rate



Drag left or right to move the scale. Zoom in or out by placing your cursor over the graph and scrolling or double clicking.

Higher rates are better for this measure

Asthma Medication Ratio: Ages 19 to 64
(FFY 2020)

Visit this measure on: Medicaid & CHIP SCORECARD

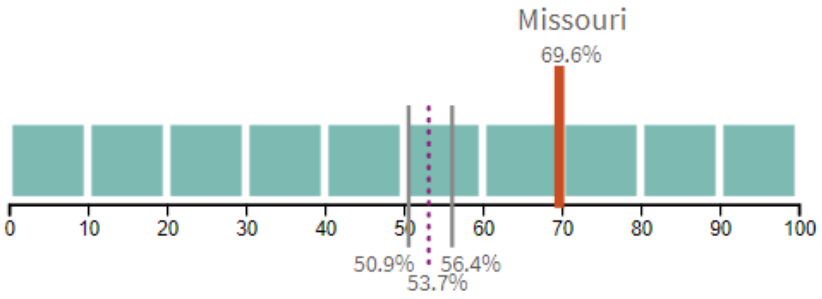
Learn more about this measure +

Rate: Select One

- Percentage with Persistent Asthma who had a Ratio of Controlle…

Population
Medicaid & CHIP

42 States Reporting **69.6%** State Rate



Drag left or right to move the scale. Zoom in or out by placing your cursor over the graph and scrolling or double clicking.

Higher rates are better for this measure

References:
1. https://www.medicaid.gov/state-overviews/stateprofile.html?state=missouri

Proposed Policy Changes (effective July 2022)

- Goal of changes: notify prescribers of over utilization of SABA and promote the use of SMART and maintenance medications to prevent exacerbations.
- Quantity limits for SABA MDI (albuterol and levalbuterol):
  - Participants ≥18 years old: 3 canisters per 180 days (3.3 puffs per day)
  - Participants with cystic fibrosis are excluded from the quantity limit
- Quantity limit for albuterol or levalbuterol inhalation solution:
  - 120 vials per 60 days
  - Participants with cystic fibrosis are excluded from the quantity limit

Communication Plan

- Outreach to MO HealthNet Providers via:
  - Provider e-mail blasts
  - Direct communication with provider groups, including prescribers and pharmacies
  - MHD staff available to speak to provider groups at conferences and webinars
  - Drug utilization review message is already being sent to pharmacies at point of sale
  - Managed Care Organizations

BREAK

Data Update

Presented By:

Paul Stuve

Legal Aid

Presented By:

Kaitee Brown

Advocates for Family Health at Legal Aid of Western Missouri

www.lawmo.org/AFH

Legal Aid of Western Missouri:

- Since 1964, Legal Aid of Western Missouri has provided dignity, self-sufficiency, and justice through quality civil (non-criminal) legal assistance for those who have nowhere else to turn
- LAWMO provides free legal representation to low-income citizens residing in a 40-county service area
- LAWMO's funding comes from a wide variety of federal, state, and local government sources; foundations; law firms; and individuals

Advocates for Family Health Project (AFH):

- Ombudsman program created to assist families experiencing problems with their MO HealthNet benefits, primarily under the Family Medicaid Programs (i.e., managed care population)
- AFH at LAWMO currently consists of two attorneys and one paralegal, with support as needed from other members of the Public Benefits Team

AFH (continued):

- Assists with family MO HealthNet (Medicaid) eligibility & application issues
- Helps participants having problems with their Managed Care Plan or unpaid medical bills that should have been paid for by MO HealthNet coverage
- Advises and assists with denial of service or equipment appeals

Opportunities for Improving Participants' Understanding of Managed Care Coverage:

- FSD & MHD: educating AEG applicants/recipients about benefits
  - What is available under MHABD vs. AEG coverage
  - Whether MCO enrollment pending

Opportunities for Improving Participants' Understanding of Managed Care Coverage (cont.):

- MCOs: continuing member outreach & education
  - Role of MCOs/subcontractors
  - MCO appeal vs. SFH

Opportunities for Improving Members' Navigation of the Managed Care Appeal Process:

- Revising Adverse Benefit Determination notices to more clearly explain:
  - why benefit was denied;
  - what appeal rights are; and
  - what happens after an appeal is requested

Contacting Legal Aid of Western Missouri:

Legal Aid is comprised of a Central Office in Kansas City and numerous smaller offices focusing on specific practice or geographic areas.

LAWMO's AFH Team is located in the Central Office.

Central Office:

4001 Blue Parkway, Ste. 300
Kansas City, MO 64130
(816) 474-6750

AFH Project:

Toll-Free Number: 1.866.897.0947
Fax: 816.474.9751
Website: **https://lawmo.org/AFH**

Missouri Department of SOCIAL SERVICES

MoHealth Net

QUESTIONS & COMMENTS